



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

MFDR Tracking #: M4-10-2758-01

DWC C

Injured

Respondent Name and Box #:

TEXAS MUTUAL INSURANCE CO.
Box #: 54

Date of

Employ

Insuran

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "...Carrier's payment of \$8,763.33 is less than the amount that Vista Hospital of Dallas should have been reimbursed. Specifically, \$1,350.24. It is unclear what methodology Carrier used to calculate reimbursement, but it is clear that the amount reimbursed is insufficient under the Fee Guideline..."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - \$1,350.24

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "...The following is the carrier's statement with respect to this dispute. Texas Mutual is willing to settle this dispute between the two parties at the amount of \$864.77 suggested on the request for reconsideration..."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
02/10/2009	Hospital Inpatient Services	N/A	\$1,350.24	\$0.00
			Total Due:	\$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.404 sets out the fee guidelines for the reimbursement of medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008:
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Wavelength: 1000-1500 nm



THE UNIVERSITY OF CHICAGO

Explanation of benefits dated 06/04/2009

- CAC-W1 – Workers Compensation State Fee Schedule Adjustment;
- CAC-97 – The benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated;
- 217 – The value of this procedure is included in the value of another procedure performed on this date;
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup;
- 494 – Hospital Outpatient allowance was calculated to the Medicare's methodology plus a markup per the Texas Fee Schedule; and
- 618 – The value of this procedure is included in the value of another procedure performed on this date.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Tex. Admin. Code §133.20?
2. Does the medical documentation provided support the services billed under §134.404?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with §133.20 the Requestor has submitted the medical bills to the Respondent timely.
2. Review of the submitted dispute shows the Requestor has supported the services billed.
3. According to the Respondents position statement the Carrier was will to settle the dispute with the Provider for an amount of \$864.77. The Respondent was contacted and a copy of the check and Explanation of Benefits was submitted to support the Provider and Carrier entered into an agreement. The Respondent reimbursed the Requestor \$864.77 plus \$30.30 as the interest payment with check number 10496243 dated 04/07/2010. Pursuant to §133.307(e)(3)(A), the Division has determined that a dispute no longer exists.

Conclusion For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.


Authorized Signature


Auditor III
Medical Fee Dispute Resolution

5/19/10
Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

